Legislative Council Staff
Nonpartisan Services for Colorado's Legislature

Memorandum

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TO: Interested Persons

FROM: Samantha Lattof, PhD MSc, Science and Technology Policy Program Fellow

SUBJECT: Navigating the GLP-1 Landscape: Evidence-Based Insights

Contents

Overview

This memo covers the clinical, demographic, coverage, and regulatory landscapes of glucagon-like peptide 1 (GLP-1) receptor agonists as of early 2026. It details the resolution of previous drug shortages, the subsequent restrictions on compounded versions, and the approaches states are taking toward coverage and cost management. Socially, while many patients using these medications for weight loss report the emotional benefit of feeling "normal," emerging research highlights complex challenges such as persistent weight-related stigma and potential entwinement with disordered eating. Finally, this memo addresses the fiscal impact on state-funded programs in Colorado, patients, and overall healthcare costs, noting that while these drugs offer clear clinical benefits, it will take years to potentially realize long-term savings.

Clinical Landscape

GLP-1s, first approved as a treatment for diabetes over 20 years ago, can enhance the secretion of insulin to help regulate blood sugar. In addition to being used to treat type 2 diabetes, GLP-1s with the active ingredients semaglutide or tirzepatide have been especially effective as a weight-loss treatment by decreasing appetite and slowing digestion.

Additional research is needed to understand whether weight loss from GLP-1s is sustainable over longer time periods. Initial research suggests patients might need to remain on GLP-1s for maintenance, as stopping the medication has caused patients to regain significant weight (Wilding 2022). That said, medication alone is rarely a permanent solution for weight loss. Lifestyle support, including behavioral therapy and nutritional support, can help provide wraparound support.

Clinicians also prescribe GLP-1s to treat comorbidities associated with type 2 diabetes and obesity, like cardiovascular disease, obstructive sleep apnea, and peripheral artery disease. Additionally, researchers are exploring the use of GLP-1s to treat other conditions like arthritis, inflammatory bowel disease, metabolic liver disease, neurodegenerative and substance use disorders, and type 1 diabetes.

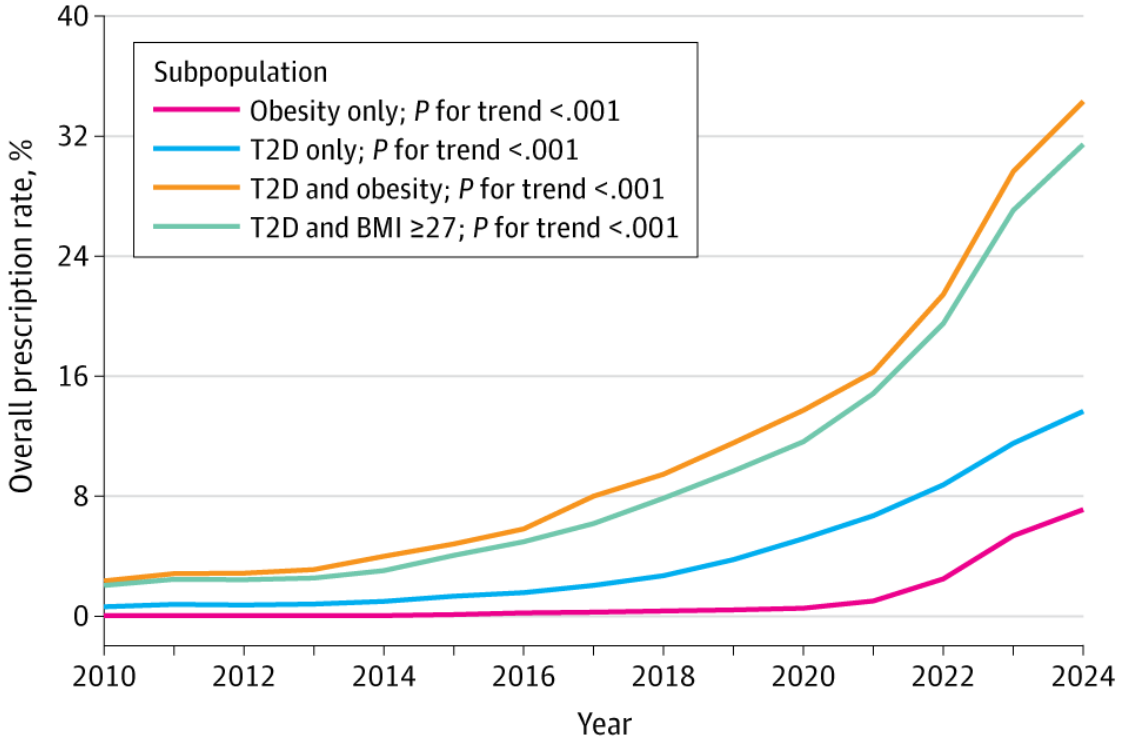
Demographic Landscape

Nationally, one in eight adults currently take a GLP-1 drug for weight loss or to treat a chronic condition, according to a 2025 KFF Health Tracking Poll. Current use was highest among adults aged 50-64 years (22 percent) and declined in adults aged 65 and older (9 percent), likely due to Medicare's lack of coverage for weight loss. Adults currently using GLP-1s reported being

informed by their health providers that they had diabetes (45 percent), heart disease (29 percent), and overweight or obesity (23 percent).

Using electronic health records of over 300 million residents in the United States, researchers examined GLP-1 prescribing trends for type 2 diabetes and obesity from January 1, 2010 to January 1, 2025 (Li et al., 2025). During that time period, they found that overall GLP-1 prescription rates increased most substantially for patients with type 2 diabetes (T2D) **and** obesity (from 2.4 to 34.3 percent) (Figure 1). Prescriptions for patients with obesity only rose from 0.04 percent to 7.1 percent.

Figure 1
Annual GLP-1 Prescription Rates Among Different Subpopulations (2010-2024)



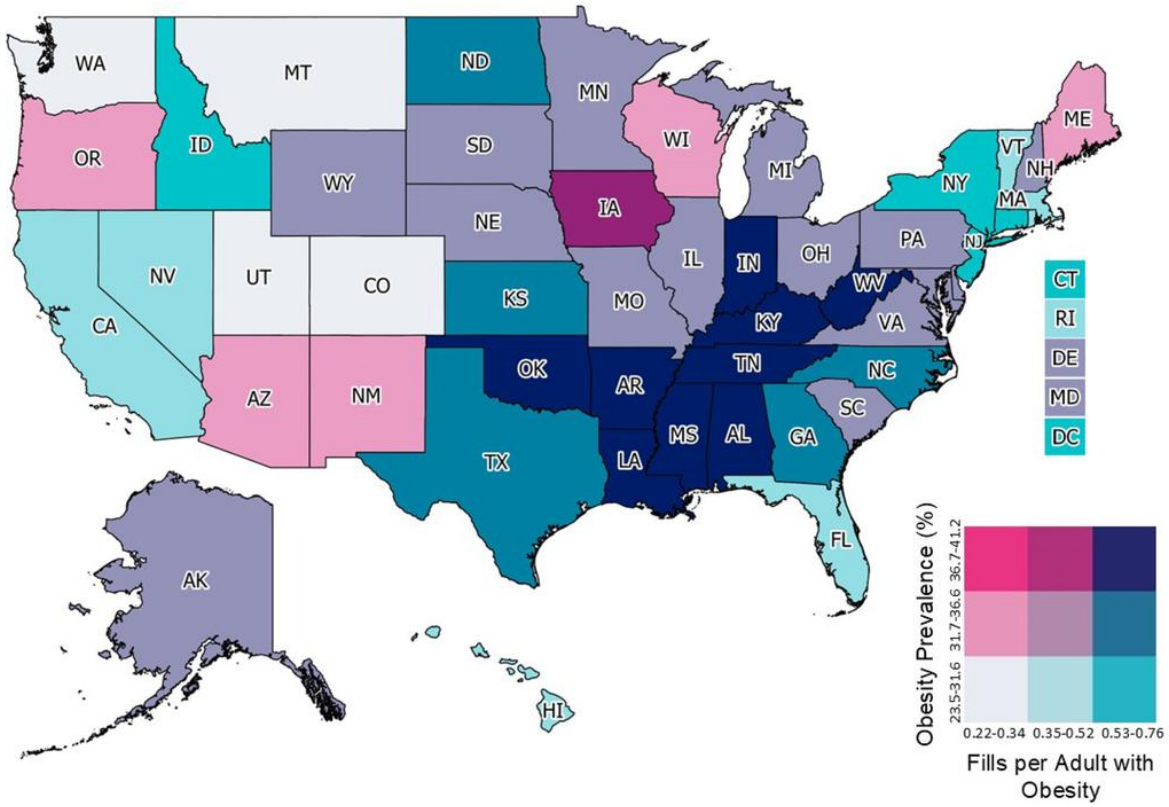
Source: Li et al., 2025

As a state with below average obesity prevalence[1] and GLP-1 fill rates (Figure 2), the situation in Colorado differs from most other states. Data from 2023, when Colorado's obesity prevalence was 24.85 percent, found that the state's GLP-1 fill rate per adult with obesity was 0.29 (Khan et

[1] Prevalence refers to the proportion of a population who have a specific characteristic (e.g., obesity) in a given time period (e.g., in the year 2023).

al., 2025). For every ten adults with obesity in Colorado in 2023, three of them filled prescriptions for GLP-1s. The situation in Colorado was most comparable to Utah, Montana, and Washington.

Figure 2
State-Level Obesity Prevalence and GLP-1 Fills (2023)



Source: Khan et al., 2025

Spending on GLP-1s in Colorado, represented by the amounts directly spent by adult patients and insurers on GLP-1 fills at the point of sale (not adjusted for rebates, discounts, or price concessions) totaled $430 million in 2023 (Khan et al., 2025). This figure included any copays, insurance coverage, or other related costs to fill GLP-1 prescriptions. Based on the total cost of GLP-1 prescription fills divided by counts of adults with obesity in Colorado, the GLP-1 spending per adult with obesity was $370 per fill.

Using data from the University of Colorado Health system electronic health record (EHR) and the Colorado All-Payer Claims Database, scientists examined how often patients with health insurance filled prescriptions for GLP-1s, their out-of-pocket (OOP) costs, and sociodemographic differences (Sarpatwari et al., 2025). Among the 6,049 patients in Colorado included in this study, the researchers found trends like:

- The average patient age was 60.9 years;
- Non-Hispanic Black patients and Hispanic patients were less likely to fill their orders than non-Hispanic White patients;
- Patients with diabetes and obesity were likelier to fill their orders than patients with only diabetes or obesity;
- Patients with diabetes and obesity had lower OOP costs ($70.32) than patients with obesity only ($134.04), possibly reflecting greater insurance coverage for diabetes; and
- Forty percent of orders for GLP-1s went unfilled.

While this research provides initial data on access to GLP-1s and OOP costs, the authors acknowledge that the results should be viewed with caution. The data from January 2018 through September 2022 preceded widespread use of GLP-1s for treating obesity, and the researchers could not obtain additional information that might provide helpful context (e.g., reasons for nonadherence, medications purchased with cash rather than insurance, data from other health systems).

Coverage Landscape

Medicaid

Medicaid covers GLP-1s for indications like diabetes, cardiovascular disease, and sleep apnea. However, some state Medicaid programs have restricted coverage of GLP-1s for weight loss for fiscal reasons. Longer-term fiscal uncertainty, federal Medicaid cuts, and tighter budgets have made it challenging to cover a weight loss medication for which upfront spending precedes measurable savings by many years, if at all.

Pharmaceutical companies have offered rebates for the drugs, which has helped reduce Medicaid spending. KFF reported that "GLP-1s accounted for over 8% of all Medicaid prescription drug spending before rebates in 2024 (up from 1% in 2019)." After rebates, GLP-1 prescription accounted for about 1% of all Medicaid prescriptions in 2024.

To assist states in obtaining GLP-1s at lower prices, the federal government announced the BALANCE (Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth) Model that will launch in May 2026. State Medicaid agencies choosing to opt in to the program will receive support from the Centers for Medicare & Medicaid Services (CMS) that will negotiate drug pricing and coverage terms with pharmaceutical manufacturers on behalf of participating states.

Medicare

Medicare coverage of GLP-1s for weight loss drugs is prohibited by law. However, Medicaid covers GLP-1s for type 2 diabetes, cardiovascular disease, and sleep apnea.

In July 2026, CMS plans to implement a new Medicare GLP-1 payment demonstration as a short-term bridge to the BALANCE model. Some Medicare beneficiaries enrolled in Medicare Part D who meet the negotiated access criteria will be able to access GLP-1s for weight management, paying $50 per month for their GLP-1 medications.

Private Insurance

While the 2025 KFF Health Tracking Poll noted that most respondents had insurance that covered a part of the cost, one in four people with health insurance paid the full cost for GLP-1s themselves. Some health insurance plans have ended coverage of GLP-1s for weight loss and weight management, while maintaining coverage for type 2 diabetes (e.g., Mass General Brigham Health Plan). Other plans require prior authorization.

Research from the Employee Benefit Research Institute[2] in 2025 found that employer coverage of GLP-1s is expanding, with 55 percent of employers covering GLP-1s for diabetes and 36 percent covering GLP-1s for both diabetes and weight loss. However, expanding coverage of GLP-1s increases employment-based health insurance premiums by as much as 13.8 percent.

To help make GLP-1s more affordable to individuals, the Trump administration announced a deal with Eli Lilly and Novo Nordisk that lowers the cost of GLP-1s purchased directly from manufacturers through the TrumpRx website. However, the National Academy for State Health Policy notes that it is currently unclear if or how this direct-to-consumer option would benefit individuals with employer-sponsored health insurance or commercial health insurance.

[2] Aon, Blue Cross Blue Shield Association, JP Morgan Chase, and PhRMA funded this research.

Regulatory Landscape

Food and Drug Administration

In 2017 and 2019, the United States (U.S.) Food and Drug Administration (FDA) approved two GLP-1 drugs with semaglutide for treating type 2 diabetes: Ozempic and Rybelsus, respectively. In 2021, the FDA approved a new semaglutide medication for weight loss management, Wegovy. The FDA approved Wegovy for reducing the risk of major cardiovascular events in patients with a history of heart disease in 2024, and as of December 2025, the FDA approved Wegovy in pill form.[3] Novo Nordisk produces all three of these drugs.

In 2022, the FDA approved a GLP-1 drug containing tirzepatide for diabetes treatment: Mounjaro. The following year, the FDA approved Zepbound, a GLP-1 drug for weight-loss management containing tirzepatide. Eli Lilly produces both drugs. In 2024, the FDA approved Zepbound as a treatment for moderate-to-severe obstructive sleep apnea. Zepbound is the first drug therapy specifically indicated for obstructive sleep apnea.

Drug Shortage and Resolution

In 2022, demand for GLP-1 medications like semaglutide (e.g., Ozempic, Wegovy) and tirzepatide (e.g., Mounjaro, Zepbound) resulted in drug shortages. When a drug shortage occurs, the FDA may temporarily ease some federal law restrictions on drugs that appear on the agency's drug shortages list. Temporarily easing the restriction on compounding, for example, makes medication accessible to patients impacted by a shortage.

The proliferation of compounded GLP-1 medications resulted in numerous challenges. Health experts' concerns ranged from fraudulent compounded drugs to sterility to the legality of producing large volumes of compounded versions of commercial drugs.

A 2024 study in Colorado identified 93 business websites advertising compounded GLP-1 products for weight loss at 188 physical locations throughout Colorado (DiStefano et al., 2024). Medical/health spas (35.5 percent) and weight loss services (28.0 percent) were the most common businesses advertising these compounded products.

The FDA formally declared the tirzepatide shortage resolved in December 2024 and the semaglutide shortage resolved in February 2025. Following these resolutions, the FDA sent warning letters to compounders producing copies of GLP-1s and released a report of over 1,100

[3] While Rybelsus is also an oral semaglutide, it is approved only for type 2 diabetes and only at lower doses.

adverse events linked to compounded GLP-1s. As of January 2026, the national supply of both types of GLP-1 drugs are considered stable.

Compounded Versions of GLP-1s

Following the resolution of these drug shortages, compounded copies of GLP-1 drugs are generally no longer allowed under most circumstances. Patients whose medical needs cannot be met with an FDA-approved drug may still be able to access GLP-1 drugs through compounding pharmacies, though the FDA has issued a statement expressing concern with compounded versions of these drugs for weight loss.

State Legislation and Policies for GLP-1s

States have attempted to address GLP-1s through legislation as well as state agency rulemaking.

State Legislation

Colorado's General Assembly introduced the Diabetes Prevention & Obesity Treatment Act (Senate Bill 24-054) in 2024. This bill would have required insurers to cover obesity treatments, including medication, and it would have required the state to seek federal authorization to provide similar obesity treatments in Medicaid. The bill ultimately failed. In 2025, the legislature passed the Diabetes Prevention & Obesity Treatment Act (Senate Bill 25-048), which requires large group health benefit plans to provide coverage for the treatments for obesity and pre-diabetes. The bill also requires carriers offering large-group health plans to offer policyholders the option to purchase coverage for FDA-approved anti-obesity medications, including GLP-1 medication.

Colorado's bill does not require a carrier to offer coverage of GLP-1 medication if premiums would not cover expected benefits, and it applies only to state-regulated large group health plans. Some health plans operating in Colorado are self-funded and subject to federal law rather than state regulation.

Additional states have passed legislation to regulate or expand access to GLP-1s:

- **Connecticut** passed a bill (2025 CT H 7192), that made recommendations around drug pricing and payment; industry, cost sharing, and deductibles; and pharmacy benefit managers. With regard to GLP-1s, the bill instructed the state's Commissioner of Social Services to advocate for federal approval of generic GLP-1s.
- **Florida** passed an appropriations bill (2024 FL H 5001) that included an authorization for the Department of Management Services to pilot a program for the treatment and management

of obesity and related conditions, including education around the efficacy and potential impacts of GLP-1s as well as education regarding tapering or continued use of these medications.

- **Illinois** passed legislation in 2024 (HB 3641) requiring the state employee health plan to cover a range of weight-loss medications.
- **Michigan** passed an appropriations bill (2025 MI H 4706) directing the Department of Health Services to limit the authorization for anti-obesity GLP-1s to individuals classified as morbidly obese, contingent on documented failure of all other clinically appropriate weight-loss interventions and only as a measure to avert the need for higher-cost bariatric surgery.
- **North Dakota** passed a house concurrent resolution in 2023 (HCR 3011) that amended the state's Essential Health Benefit clause, covering weight-loss drugs like GLP-1s as a therapy for certain conditions.

State Coverage Policies

As of January 2026, 13 state Medicaid programs covered GLP-1 medications for weight-loss/obesity treatment under fee for service, though GLP-1s may be subject to controls like prior authorization. The 13 states are: Delaware, Kansas, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, North Carolina, Rhode Island, Tennessee, Utah, Virginia, and Wisconsin. Three of these states (Michigan, Rhode Island, and Wisconsin) are reportedly planning or considering additional restrictions.

While California, New Hampshire, Pennsylvania, and South Carolina had Medicaid programs that previously covered GLP-1s for obesity, these states have since eliminated coverage. California, for example, ended its Medi-Cal coverage of GLP-1s for weight loss on January 1, 2026 to address a significant budget deficit.

Social and Psychosocial Impacts

Research on the social and psychosocial impacts of GLP-1 use are sparse. Researchers have started exploring the effects of these drugs on adolescents' psychosocial functioning but recognize that additional research is needed (Jhe et al., 2025). Based on qualitative social science studies with adults using GLP-1 medications for weight loss in the United States, Brazil, Denmark, Japan, and online communities, researchers identified nine emerging social trends around initiation and use of GLP-1s (Jensen et al., 2025):

1. The joy of feeling "normal;"

2. Weight anxiety, not just weight, shapes GLP-1 demand;
3. Willingness to suffer, sacrifice, and strategize to gain and maintain access to GLP-1s;
4. Extensive and imaginative medication tinkering (including to ration costly or scarce medication) and unregulated seeking;
5. Changing dynamics in clinic consultations, making it easier for physicians and patients to discuss weight loss;
6. Complex entwinement with disordered eating;
7. "Sex" differences are likely gender differences (e.g., many societies expect women to conform to slimmer body norms than men);
8. Social media matters, informing people's beliefs and decisions about GLP-1s; and
9. Weight-related stigma is unlikely to dissipate.

Acknowledging that prescription sharing is a strategy to gain and maintain access to GLP-1s as well as an under-researched practice, social scientists have come across cases where people borrow or give medication to family or friends for whom the medication was not prescribed (Jensen et al., 2025). In the United States, Jensen and colleagues encountered spouses sharing GLP-1 medication, such as a spouse with insurance coverage for diabetes sharing medication with their spouse who lacks insurance coverage for weight loss.

Financial Impacts

Increased coverage of GLP-1s for weight loss could impact state-funded programs in Colorado, such as Medicaid and health insurance coverage for state employees; the cost of private health insurance in the state; and healthcare costs.

State-Funded Programs in Colorado

Covering GLP-1s for weight loss involves both estimated and realized costs to the state. These state-funded impacts relate to Medicaid coverage and the costs of providing coverage in state employee health plans.

Medicaid Impacts

The Legislative Council Staff's fiscal note for Senate Bill 25-048, as it was originally introduced, detailed the estimated fiscal impacts to the Department of Health Care Policy and Financing (HCPF) for providing Medicaid coverage for weight-loss medication to treat obesity.

Assuming that approximately 150,000 Medicaid clients would be newly eligible for weight loss medication under the original bill, LCS's initial analysis assumed that about 18,000 clients would

use the medication in Fiscal Year (FY) 2025-26, increasing to about 26,000 by FY 2027-28 at a cost of $500 per client per month after rebates. Monthly medication costs may continue to change as the FDA approves new brands for the treatment of obesity. LCS estimated HCPF would spend $71.7 million on medication in FY 2025-26, $134.2 million in FY 2026-27, and $122.9 million in FY 2027-28, after accounting for all pharmaceutical company rebates.

State Employee Health Coverage Costs

As of July 1, 2025, the Colorado Department of Personnel and Administration removed coverage of GLP-1s for weight loss under state employee health plans. While the state grandfathered in employees who were actively taking GLP-1s as of June 30, 2025, these employees' co-pays per prescription increased from $30 to $120. State officials reported that this change would save the state approximately $17 million annually.

Health Insurance Impacts

Per state requirements for Senate Bill 25-048, as it was originally introduced, independent contractors conducted an actuarial analysis of comprehensive obesity and pre-diabetes coverage that is available on the Division of Insurance website. The analysts acknowledged they could not find evidence of medical offsets after two years or any studies quantifying the long-term impact of anti-obesity medications on healthcare costs. While sustained weight loss can improve health outcomes and reduce health risks in people with obesity, the analysis noted that cost savings are highly variable. Both high-savings and low-savings models in the analysis find that "the cost savings associated with weight loss partially offset the cost of weight-loss interventions" (p. 6). Had the legislation been enacted as originally proposed, the ten-year cumulative impact on premiums (without medical cost offsets) would equate to $5.03 per member per month across all commercial markets.

Impact of GLP-1s on Healthcare Utilization and Spending

In January 2026, economists published a National Bureau of Economic Research working paper that presented one of the first large-scale quasi-experimental estimates of the real-world impacts on GLP-1s on health and healthcare utilization (Bock et al., 2026). Using data from the Veterans Health Administration (VA), which treats one of the largest diabetic and obese patient populations in the United States, the economists tracked a cohort of nearly 1.4 million obese or type 2 diabetic veterans from 2018 (when the FDA approved Ozempic) through the end of 2024. Bock and colleagues found that patients using GLP-1s had clear, significant improvements in

glycemic control and weight loss. However, these population-level health benefits diminished over time as healthier patients initiated GLP-1s. The economists found **no evidence** that increased use of GLP-1s resulted in:

- short-run improvements in broader health outcomes;
- reductions in medical spending;
- reductions in emergency department visits;
- reductions in inpatient and outpatient expenditures;
- reductions in total non-GLP-1 spending through 2024; and
- immediate cost savings for the VA.

Based on their findings, Bock and colleagues identified promising directions for future research, including whether use of GLP-1s translates into improvements in broader socioeconomic areas like fertility, employment, and labor supply.

A second National Bureau of Economic Research working paper published in January 2026 examined cost offsets from GLP-1s, that is whether the drugs lead to reduced downstream healthcare use and medical spending (Wing et al. 2026). Using health insurance claims data for 537,000 patients who initiated GLP-1 treatment for type 2 diabetes and obesity between 2017 and 2022, the economists compared patients who initiated GLP-1s at different times (a staggered difference-in-difference design). Based on their analyses, Wing and colleagues found that GLP-1 initiation actually increased other healthcare spending instead of leading to reductions. Moreover, this result persisted for at least five years after GLP-1 initiation (the length of their study period) and held up across different patient subpopulations. As a result, the economists concluded that, "payers facing the costs of GLP-1 coverage are unlikely to see large savings from reduced spending on other care. If GLP-1 therapies ultimately yield cost savings, they are likely to occur only over longer horizons or through non-medical channels."